MARYLAND HEALTH CARE COMMISSION

Status of Adverse Event Public Reporting

Ben Steffen

Presented to the
Maryland Health Quality and Cost Council
September 19, 2014

Background

- Maryland's approach to monitoring comprehensive adverse events monitoring
  - OHCQ
  - MHCC, HSCRC
  - Maryland Patient Safety Center
- Maryland agencies have broader authority than those in many other states, but gaps in oversight exist
  - Site of service may determine scope of oversight…
  - Surgery in hospital versus ambulatory surgery center
  - Various patient protections for events reportable in hospitals, not in nursing homes
  - No public reporting of adverse events
- Why consider public reporting?
  - Trends when monitoring occur, but adverse events continue
  - Movement toward greater transparency
  - Reductions in adverse events are important to success of the new hospital payment model
  - Existing patient safety efforts may be slowing, additional momentum may be needed beyond current approaches

Current Authority and Responsibilities

- OHCQ requires hospitals to report all Level 1 adverse events
  - "Adverse event" means an unexpected occurrence related to an individual's medical treatment and not related to the natural course of the patient's illness or underlying disease condition. Level 1 - adverse events that cause death or serious disability must be reported
  - Hospitals mandated to conduct root cause analysis, identify corrective actions and outcome measures.
  - Ambulatory surgical centers & nursing homes are not covered. Nursing homes covered through federal regulatory structure –certain adverse events available through the MDS
  - Public reporting prohibited under the statute
- MHCC
  - Broad public reporting authority over hospitals nursing homes, and ambulatory surgery. Adverse event reporting not part of current authority.
  - Adverse events may be collected as part of a broader initiative, , specific events (CLABSI) are part of other initiatives, such as SSI reporting
  - Designation of MPSC
  - No authority to collect adverse events
- HSCRC
  - Administers the Maryland Hospital Acquired Complications (MHAC) program
  - Hospitals performance measured through 3M Potentially Preventable Complications (PPCs)
  - 5 PPCs crosswalk to the NQFs serious reportable events

Variations exist in Adverse Reporting for Surgical Services

Surgery Volume 2008-2012						
Facility Type	**2008**	**2009**	**2010**	**2011**	**2012**	**CAGR**
Freestanding Surgical Facilities	594,914	607,939	594,993	604,012	622,340	0.9%
Single	436,108	434,959	439,106	436,202	441,388	0.2%
Limited	42,551	52,594	26,173	31,034	36,630	-3.0%
Multi-specialty	116,255	120,386	129,714	136,776	144,322	4.4%
Hospital	578,218	549,484	553,341	544,805	549,068	-1.0%
Inpatient	226,702	228,990	209,647	204,879	198,822	-2.6%
Outpatient	351,516	320,494	343,694	339,926	350,246	-0.1%

Currently, only hospitals are subject to adverse event reporting to OHCQ

Maryland Patient Safety Center

- Develop a culture of patient safety within health care facilities
- Approach emphasizes non-punitive educational initiatives that encourage full reporting that will contribute to the prevention of future errors.
- AHRQ designated Patient Safety Organization
- Key activities directly related to adverse events
  - Safe from Falls
  - Educational programs aimed at reducing errors, including adverse events -- Root Cause Analysis and Failure Mode Effect Analysis
  - 2015 initiatives – Sepsis prevention and Adverse event reporting
- No public report planned

MHCC process for redesignation

- MPSC presents to MHCC in September
- MHCC requests public comment on redesignation
- MHCC considers staff recommendation at the November meeting

Success Stories in Public Reporting: Healthcare Associated Infections (HAIs) Reporting

- Public reporting on Central Line-Associated Bloodstream Infections (CLABSI) began in 2010.
- CLABSI numbers were high when reporting began and have been significantly decreased over the years.
- In 2014, MHCC will expand this initiative to other hospital acquired infections, including CAUTI

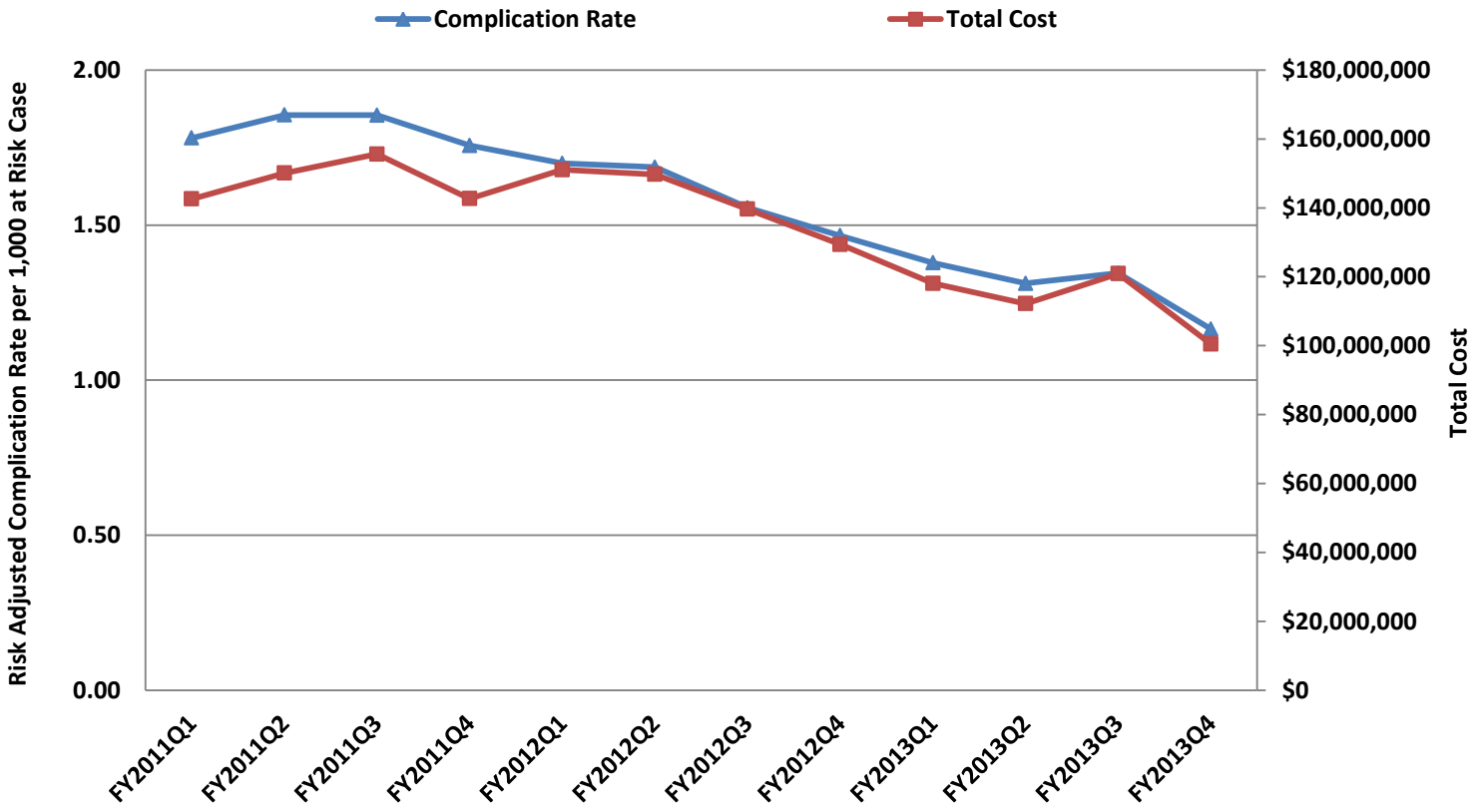
- Other Key Factors for Success
- Data verification: MHCC audits information reported by hospitals to NHSN
- Education: The Maryland Patient Safety Center worked collaboratively with the industry in reducing CLABSI
- OHCQ collects specific data on most significant infections through adverse event system

Hospital Performance: Central Line Associated Blood Stream Infections (CLABSI)

Performance Measure	FY2010	FY2011	FY2012	FY2013	Difference
All ICU CLABSIs	**472**	**296**	**206**	**187**	**Improvement (60.38% reduction)**
Adult/Pediatric Intensive Care Units					
CLABSIs	424	262	166	152	Improvement **(64.15% reduction)**
Hospitals with 0 Infections	6	12	20	17	Improvement
Hospitals Better than National Experience	0	4	8	9	Improvement
Hospitals Same as National Experience	37	39	36	36	Improvement
Hospitals Worse than National Experience	8	2	1	0	Improvement
Maryland Standardized Infection Ratio (SIR)*	1.35	0.85	0.57	0.49	Improvement
Maryland Performance (using SIR)	**Worse**	**Better**	**Better**	**Better**	
Maryland Adult/Ped ICU Central Line Days	163,757	157,706	149,736	154,118	
Neonatal Intensive Care Units (NICUs)					
Hospitals with NICUs	15	16	16	16	
CLABSIs (total)	48	34	40	35	Improvement **(27.08% reduction)**
Hospitals with 0 Infections	4	3	4	6	Improvement
Hospitals Better than National Experience	1	2	1	1	No Change
Hospitals Same as National Experience	14	14	14	15	Decline
Hospitals Worse than National Experience	0	0	1	0	No Change
Maryland NICU Central Line Days	27,299	26,817	25,926	24,666	

* The Standardized Infection Ratio (SIR) is a summary measure used to compare the infection rate of one group of patients to that of a standard population.

A developing success story: Potentially Preventable Complications



- MHAC implemented in 2009 based on 3M PPC.
- Over 5 years: hospitals must reduce PPCs by 30%
- In 2014, statewide goal is 8% reduction in PPCs. Maximum revenue increase for meeting reduction goal is 1%, maximum reduction is 4%

A Formula for Reducing Adverse Events

- Comprehensive across all sites of service
- Accurate reporting confirmed through external review
- Aligned with broader quality and financial incentives
  - Ensure the organizations subject to reporting have incentives to improve
  - Agencies with responsibilities closely collaborate
- Actionable to providers
- Accessible to the public:
  - Will require a change in statutory authority.